GOVERNMENTAL AND SOCIETAL PRESSURES FOR PROGRAMS OF CONTINUING MEDICAL EDUCATION*

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THE subject which I have been assigned begins with the assumption that there are governmental and societal pressures for continuing medical education. Why should this be so? What is the expectation of those who are applying the pressure? Where is the pressure applied? By whom? Against whom? What is the response?

These are all interesting questions, for which there are no absolute answers. We can begin, however, with certain assumptions which are in themselves revealing. First, there is the assumption that government and society consider continuing medical education desirable. This leads to the further assumption that government and society believe that continuing medical education will result in greater medical competence and, presumably, in better medical care. There is also the assumption that the pressure which is applied will be productive, i.e., that it will evoke a response of more and better continuing education and greater effectiveness in achieving better medical care.

There are those who would question the validity of all of these assumptions, but it is reasonably clear that our society does not. Perhaps this is true because we live in a society which values education and, for the most part, believes in it. Perhaps it is due to the attitude of the medical profession itself toward education. Since medicine has the longest period of formal education of any profession, it would be surprising indeed if there were not a genuine reverence for the extension of that education. Or perhaps it is simply recognition of the enormous growth of the fund of medical knowledge and the fact that it would be impossible to remain fully informed in that field of knowledge without regular exposure to new information in some organized fashion.

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Whatever the reasons, we know that the pressures for continued learning in medicine are great. The pressures on the individual physician may be either internal or external. By internal pressure I mean his self-motivation, the desire to improve and excel, his personal pride in his level of knowledge, and his desire to be at least equal to or better than his colleagues and to provide better care for his patients.

While I have not been asked to discuss specifically this type of pressure, I believe that it may be the most important of all. Without the pride and self-motivation of the individual physician, most of the external pressures are likely to be ineffective. Having observed closely 20 years of classes of medical students in one medical school and having talked with many other medical students and physicians from many other schools, I am certain that there is a high level of pride in achievement among physicians. It is popular today to malign the admissions process in medicine, but one benefit of it has been the assembling within the profession of a large group of high achievers who take pride in their work and are discontented with anything less than equality with their peers.

But I presume from my subject that I should spend most of my time talking about the external pressures on the physician. These may also be divided into two groups: those coming from within the profession and those from without. They are not always clearly separable, because pressures on physicians from within the profession may arise in response to real or perceived pressures from outside or because those looking ahead anticipate future external pressures. To some extent, also, the pressures created by the profession itself are responsible for the development of external pressures from government and society. Surprisingly, this latter phenomenon seems not to be understood well, either by the profession or the public. It is worthy of some consideration here.

It is well known by lawyers and has become a favorite theme of mine that law usually follows custom rather than the reverse. This has certainly been the case with medical education and the law. Quite by accident, recently my attention was called to the fact that in 1910 70% of the graduates of medical schools in the United States took a year of internship as a part of, or following, their medical-school education. This was four years before the first state law was written requiring a year of internship for eligibility for licensure. Such laws were then enacted successively in 37 other states.

Studies carried out in connection with the recent report of the Goals and Priorities Committee (GAP) of the National Board of Medical Examiners show that more than 90% of the medical-school graduating class of 1960 took residency training, although there is currently no law which requires this of physicians. This was prior to the emergence of the American Board of Family Practice and the new residencies in family practice which are so popular today. It is estimated that virtually all graduates of medical schools in the United States now enter residency training and that the vast majority complete that training, whether or not they become certified by specialty boards. The same is true for foreign medical graduates as well, since most of them enter this country through the path of graduate medical education.

Why do physicians take such training? Simply because it is there? But why is it there? The cynical might say it exists because hospitals have need for service! Perhaps that is so in part, but it is even more true that physicians have determined, separately as individuals and collectively through their medical and specialty societies and certifying bodies, that advanced education is necessary for the practice of modern scientific medicine. The carrot of board certification is there, of course, and the reward of greater status, recognition, and financial return, but all these things were determined initially by the profession itself. Specialty boards were established to recognize those who took advanced training and passed special examinations.

There is now some indication that governmental bodies at both state and national levels are considering requiring, through licensure or compensatory regulations, that all physicians become board certified or at least complete the education required for board certification. It is interesting to note that the Council on Medical Education of the American Medical Association (AMA) advocated, as far back as 1952, that all physicians complete at least two years of graduate medical education before entering practice.

Similar trends are readily apparent in continuing medical education. There has been a steady growth in recent years in the amount of continuing education offered and in the participation of physicians in it. Documentation of this trend is not easy because there are so many kinds of activities which defy ready documentation. But for those elements which can be documented, the results are impressive.

Each year since 1955 the AMA has listed courses in continuing medical education reported by organizations and institutions. In 1960 1,116 courses were reported and listed. In 1970 the number had grown to 2,319. In 1974 the total was 3,677. Over a similar period of time the number of registrations reported for the courses offered by medical schools increased from 39,817 to 219,660. In addition, there is good evidence that there are far more courses offered and far more actual registration than has been reported to us.

In 1964 the AMA authorized the development of a program of accreditation of institutions and organizations offering continuing medical education. Accreditation began in 1966 and the number of institutions and organizations accredited has now reached 590. In addition, 40 state medical associations have met standards of approval for the conduct of programs of accreditation for institutions or organizations sponsoring local or intrastate activities in continuing education. In effect, these state associations act as agents for the Council on Medical Education in the conduct of the program of accreditation.

These impressive statistics are some indication of the level of growth in the field. As noted earlier, however, they are only additional examples of the kinds of peer pressure exerted on the physician by the medical profession. In his monograph *Lifetime Learning for Physicians* Dr. Bernard V. Dryer cited several historical examples of statements made by groups of leaders of the profession which have pointed the way to today's events. In 1932 the final report of the Commission on Medical Education, whose director was Dr. Willard C. Rappleye (who later became Dean of the College of Physicians and Surgeons of Columbia University), included the following statements:[1]

> The continued education of physicians is synonymous with good medical practice and provisions should be made ultimately whereby every physician will be able to continue his education if he wishes to do so. . . .
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> The time may come when every physician may be required in the public interest to take continuation courses to insure that his practice will be kept abreast of current methods of diagnosis, treatment and prevention.

A second citation by Dr. Dryer was from the inaugural address of Dr. J.H.J. Upham, as president of the AMA in 1937:[2]

> There is already a trend toward compulsory evidence of post-

> graduate improvement . . . in several states there are laws requiring annual registration of physicians . . . there is a possibility that the next step might be requirement for renewal of licensure through evidence of familiarity with the developments in medicine by five or ten year periodic examinations.

A similar statement was included in the Walter L. Bierring Lecture delivered by AMA President Gunnar Gundersen, M.D., before the Federation of State Medical Boards in 1959:[3]

> . . . the quality of medical care rendered will not be uniformly of the high standard that the public has every right to expect without some definite stimulus to insure that all practicing physicians regularly keep abreast of important developments in medicine. Here are some of the many possible forms that this stimulus could take:
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> 1. It could be a requirement of licensing that holders of licenses must at intervals demonstrate (through re-examination) that they have retained important basic knowledge and competencies and have kept up through significant advances.
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> 2. Or it could be a requirement of licensing boards that holders of their licenses regularly participate in acceptable programs of continuing medical education.
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> 3. This stimulus could be made in non-governmental function by making re-examination, postgraduate education, or both, requirements for continuing membership in organized medicine, specialty and other medical associations.

The foregoing were expressions of opinion delivered by leaders in the profession, but for the most part they were years ahead of tangible action by organized groups. The first such action was that taken when the American Academy of General Practice (AAGP)—now the American Academy of Family Physicians—was organized in 1947. One of the conditions of membership in that organization was the requirement that members participate in at least 150 hours of continuing medical education every three years. Although it did not attract great professional attention at the time and was not followed quickly by similar actions by other organizations, this action now looms as a landmark; it has served as the basis for many similar actions taken in recent years. Today the only other specialty society to require continuing education as a basis for membership is the American College of Radiology,

which in 1974 also instituted a requirement of 150 hours for each three years of membership. Several other specialty societies, however, including the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists, have instituted voluntary programs which urge a similar level of participation.

In 1968 the Oregon State Medical Association became the first state medical society to require continuing medical education as a basis for membership. Similar actions were taken subsequently by other state medical associations, so that there are now 12 such societies which require participation in stated amounts of documented continuing medical education. While the requirements are not exactly the same from state to state, most of them have been based upon the standards set by the AAGP of 150 hours every three years.

This was also the basis of the AMA's voluntary Physician's Recognition Award which was established in 1969 and is now in its second three-year cycle. More than 40,000 physicians have applied for and received the Recognition Award, which identifies six categories of activities of continuing education among which the required 150 hours may be divided. At least 60 of these credit hours must be spent in activities of continuing medical education offered by accredited sponsors. In this way the Physician's Recognition Award is linked with the AMA's program for the accreditation of institutions offering continuing medical education.

While the AMA's Recognition Award is voluntary, it is tied closely to the mandatory programs of the state medical societies in that most of them will accept the Physician's Recognition Award as meeting their requirements. Some physicians have deprecated the giving of credits and certificates for the participation of physicians as a "Brownie point" approach, but there is no doubt that these incentives have a strong persuasive effect upon many physicians.

In keeping with this philosophy, the AMA House of Delegates at its annual convention in June 1973 adopted a strong Policy Statement on Continuing Medical Education which reads as follows:[4]

> The American Medical Association is a professional organization dedicated to scientific excellence and the delivery of high-quality medical care to the American public.
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> The American Medical Association believes strongly that regular participation in continuing medical education is essen-

tial to the maintenance of professional competence. The AMA believes that every member of the Association and every other physician should plan and engage voluntarily in a regular program of continuing education designed to maintain his personal professional competence.

The American Medical Association recommends that every physician participate voluntarily in regular self-assessment procedures to identify his own level of professional knowledge and compare it with a level considered desirable by his peers.

Recognizing that there is wide variation in learning habits and the conditions under which individual physicians may participate, the American Medical Association stands ready to assist physicians in the design and implementation of their personal programs of voluntary continuing medical education.

The AMA Physician's Recognition Award has been established as a means of recognizing physicians who participate in a stated amount of continuing education on a regular basis. The standards for the Award represent an expression of an acceptable level of involvement in continuing medical education for every physician. The American Medical Association urges every physician to meet or exceed the standards of the Physician's Recognition Award in his personal program of continuing medical education.

It was noted earlier that specialty societies have played an active part in developing programs of continuing education and in requiring or encouraging their members to participate in such programs. One facet of this has been the remarkable growth of self-assessment procedures. Although the American Society of Clinical Pathologists might be said to have used a form of self-assessment for its members since the early 1920s the growth of modern self-assessment examinations began with the development of the first modern self-assessment examination by the American College of Physicians in 1968. The rousing success of this experimental venture undoubtedly encouraged other specialty societies to follow suit, with the result that there are now 24 self-assessment programs in operation or in development by various specialty societies. Most recently, these have been tied closely to the movement toward periodic recertification by specialty boards.

The specialty boards now constitute one of the strongest motivat-

ing forces which the medical profession can apply to its members. Once again the way was shown by the family-practice group. When the new American Board of Family Practice was established in 1969 it stated that its certificates would be good for only six years and would have to be renewed at six-year intervals thereafter. Since the first certificates were awarded in 1970 the first recertification procedure will be in 1976. The exact nature of the requirement for recertification has not been determined yet but the current plans are to weight the criteria so that one third will be based upon an examination of new developments, one third on the evidence of participation in continuing education, and one third on an audit of office records.

The American Board of Medical Specialties (ABMS) was established in 1970 as a result of a reorganization of the long-standing Advisory Board for Medical Specialties (organized in 1933). After its reorganization the ABMS established several standing committees, including a committee on certification, subcertification, and recertification (COCERT). One of the major activities of COCERT has been to develop proposals on periodic recertification of medical specialists. At the annual meeting of the ABMS in March 1973 the members endorsed the following recommendation of COCERT:[5]

> . . . that ABMS adopt in principle, and urge concurrence of its member boards, the policy that voluntary periodic recertification of medical specialists become an integral part of all national medical specialty certification programs and further that ABMS establish a reasonable deadline when voluntary periodic recertification of medical specialists will have become a standard policy of all member boards.

All of the 22 specialty boards of the ABMS subsequently endorsed in principle the concept of periodic recertification. Three specialty boards in addition to family practice—internal medicine, surgery, and plastic surgery—have announced specific dates for procedures of recertification. One of these, internal medicine, offered its first voluntary recertification examination in the fall of 1974. To date, only the family-practice board has made recertification a requirement, but the American Board of Surgery has announced that recertification will be mandatory every five years for diplomates certified in 1975 and thereafter.

Unquestionably, the movement toward periodic recertification, whether voluntary or mandatory, will constitute a powerful stimulus to all specialty-board diplomates to continue their education regularly so that they will be prepared for whatever procedures of recertification are developed. While less than half of the physicians in the United States are currently certified by specialty boards, the boards are relatively young organizations and virtually all recent graduates of American medical schools have entered residency training with the expectation of ultimately becoming certified by a board. Consequently, the proportion of diplomates is much higher among young physicians than among the older generation. Once again it should be noted that this is peer pressure that comes from within the profession rather than from outside.

Other movements are also worthy of note. It has been reported that many individual hospitals, through their professional staff regulations, have now required professional staff members to participate in stated amounts of continuing education on a regular basis in order to maintain their hospital staff privileges. So far, this movement has been quite spotty and confined to relatively few institutions. However, a substantial number of California hospitals have apparently instituted such requirements, and I recently learned that three hospitals in Chicago now require their members to qualify for the AMA Physician's Recognition Award in order to retain their staff privileges.

The Joint Commission on Accreditation of Hospitals has also given a boost to the other pressures by specifying that each hospital must have a plan whereby its professional staff members will participate in a regular program of continuing medical education. The requirement does not specify that the hospital itself must offer the program, but merely that there be a plan whereby such a program is carried out. Once again this may be regarded as an intraprofessional stimulus, even though the joint commission, by virtue of the importance of its accreditation program, may be assumed to have quasilegal significance.

Finally, some reference should be made to the recent report of the Goals and Priorities Committee of the National Board of Medical Examiners (NBME). While most of the emphasis in that report has been on examination at the undergraduate and graduate levels of medical education, there were also recommendations concerning the evaluation of continuing professional competence during practice. The re-

port recommends that the NBME[6] "should take the initiative in developing methods for evaluating continuing professional competence in relation to the quality of health care" and that these efforts" should be coordinated with those of other professional groups concerned with developing effective mechanisms useful for recertification." These recommendations are more directly related to examination than to continuing medical education, but they constitute an additional professional pressure on the physician to participate in continuing medical education in order that he might be able to deal with future examinations if they should be required of him.

It is obvious from the above that there are extensive and comprehensive activities in progress within the profession which exert substantial peer pressure upon individual physicians to participate in continuing medical education. There are other pressures, however, which may be classified as being outside the profession, even though they are interrelated to activities within the profession. As examples, one could cite reports from national governmental bodies which have made recommendations on the subject. The first of these to receive significant attention was the report of the National Advisory Commission on Health Manpower in November 1967. This commission, which was appointed by President Lyndon Johnson, made many recommendations, one of which was "that professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or on the basis of challenge examinations in the practitioner's specialty." More recently, the Commission on Medical Malpractice—which was established by Elliot L. Richardson, secretary of the Department of Health, Education, and Welfare in 1972 and which reported early in 1973—made the following recommendations:[7] "the Commission recommends that the states revise their licensure laws, as appropriate, to enable their licensing boards to require periodic reregistration of physicians, dentists, nurses and other health professionals, based upon proof of participation in approved continuing medical education programs." The commission also recommended "that specialty boards periodically re-evaluate and recertify physicians they have certified."

As of this date there has not been extensive legislation to require

the periodic relicensure of physicians. However, four states have modified their medical-practice acts to give their boards of medical examiners the authority to require evidence of continuing medical education as a condition for the reregistration of the medical license; they are Kansas, Kentucky, Maryland, and New Mexico. Of these, Maryland and New Mexico have already implemented this permissive legislation while the other two have not yet announced their intention of doing so. The Physician's Recognition Award fulfills the requirements of both the Maryland and New Mexico boards of medical examiners. Informal information received from other boards of medical examiners indicates that perhaps as many as a dozen additional states have similar legislation under consideration. The AMA has taken a position against the requirement of periodic relicensure through legislation, reasoning that the disadvantages significantly outweigh the potential advantages and expressing the opinion that far more can be accomplished through encouragement and exhortation by the profession itself through its various societies.

Recently proposed legislation shows that there are those in Congress who favor the enactment of either state or federal laws to require physicians to be licensed periodically. The Health Manpower Bill (S-3585) introduced by Senators Edward M. Kennedy and Jacob K. Javitz proposed that a national licensing program be established for physicians under which licenses would have to be renewed every six years. Ultimately, S-3585 was amended substantially before being passed by the Senate and the licensing provisions were removed. There can be little doubt, however, that this area is now regarded as fair game by legislators, and it is entirely possible that such provisions will be reintroduced in subsequent legislation.

These activities raise fundamental questions which have important implications for the future of continuing medical education. Much time has been spent debating whether voluntary or mandatory continuing education is better. Understandably, most physicians favor voluntary proposals. If one studies the history of the development of standards for medical education and certification in the United States, however, it would appear that there is ultimately little difference between the two. As noted in the beginning of this presentation, the power of peer pressure is very great and the innate desire of medical professionals to excel and to match the performance of their peers

is such a powerful stimulus that any generally established voluntary procedure soon develops the effective force of mandatory procedures.

The entire process by which educational programs have been subjected to procedures of accreditation and the growth of formal graduate and now continuing medical education within the profession reveal quite clearly that an overwhelming majority of physicians will follow whatever educational prescriptions are written by the profession at large. Consequently, if most medical-school graduates participated in graduate medical education it would be difficult for the remaining few to refuse to do so, even if they do not believe in the value of the process. Similarly, if most physicians become certified by specialty boards and then subject themselves to periodic recertification it seems likely that the vast majority of the profession will do the same. Eventually, after the profession has adopted this custom, external legal bodies will make the custom the law—or at least establish a system of rewards in medicine on the basis of the credentials which have been earned. The effect would be virtually the same in either case.

A good case can be made, however, that more is accomplished by pulling the profession up from the top than by attempting to push it up from the bottom. Efforts which concentrate upon the small percentage of the "unwashed and unwilling" will inevitably set their sights lower than those which aim at the encouragement of standards of excellence. With the vast majority of the members of the profession striving for excellence, it then becomes difficult for the laggards to remain far behind the pack. The result in the final analysis is probably a much higher level of performance than if one deals with minimum requirements established through legal provisions of licensing. The case for voluntarism appears to be very strong and in the public interest as well as in the professional interest.

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